MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03974

CERTIFICATE OF DEATH

03970

1

1. PLACE OF DEATH
a. COUNTY: WORCESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
c. LENGTH OF STAY IN 1b: 10 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Synepuxent

2. USUAL RESIDENCE (Where deceased lived, If Institution, Residance before admission)
a. STATE: MARYLAND
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X BERLIN R.F.D.
d. STREET ADDRESS: SYNEPUXENT
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First EDWARD Middle LEE Last CAREY

4. DATE OF DEATH: Month MAR Day 21 Year 1962

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: FEB. 6, 1912

9. AGE (In years last birthday): 50 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOTEL OWNER, MARINA

10b. KIND OF BUSINESS OR INDUSTRY: FARM - DOCKS

11. BIRTHPLACE (County & State, or foreign country): OCEAN CITY MD

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: EDWARD J. CAREY

14. MOTHER'S MAIDEN NAME: SAVANNAH DENNIS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): YES — (If yes give war or dates of service): WORLD WAR 2

16. SOCIAL SECURITY NO.:

17. INFORMANT: MRS E. L. CAREY — Address: BERLIN R.F.D. MD

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion acute — INTERVAL BETWEEN ONSET AND DEATH: [redacted]
DUE TO (b): Artio sclerotic Heart Disease — [redacted] years
Conditions, if any, which gave rise to immadiate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING [ ] **OR CONTRIBUTING** [ ] **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from MAR 1962 to MAR 22 1962, That (I) (~~we~~) last saw the deceased alive on MAR 15 1962 and that death occured at M, from the causes and on the date stated above.

22a. SIGNATURE: F. Townsend Jr. M.D.

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: MAR 24, 62

22c. PHYSICIAN'S NAME (Type): FRANCIS J TOWNSEND, JR

22d. ADDRESS: Ocean City, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 3/25/62

23c. NAME OF CEMETERY OR CREMATORY: ST PAULS CHURCH YARD

23d. LOCATION (City, town or county) (State): BERLIN MD.

24 FUNERAL DIRECTOR'S SIGNATURE: Anna A. Burbage — **ADDRESS**: Berlin Md

25a. REC'D BY REGISTRAR DATE: MAR 30 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kinna

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03975 03971

1. **PLACE OF DEATH**
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Girdletree
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Home

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Girdletree
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Natalie Middle: E. Last: Conner

4. **DATE OF DEATH**: Month: Mar. Day: 10 Year: 1962

5. SEX: F.

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 1, 1906

9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Factory

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Taylor

14. MOTHER'S MAIDEN NAME: Rosie Collick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give wars or dates of service): No.

16. SOCIAL SECURITY NO.: 219-05-7366

17. INFORMANT: Address: John Conner Girdletree, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 1 wk
DUE TO (b): Arteriosclerotic hypertension
DUE TO (c): Cardiovascular renal disease — 5 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4 4 2 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1957, 19..., to 3-10-62, 19..., that (I) (we) last saw the deceased alive on 3-10-62 19..., and that death occured at ...M, from the causes and on the date stated above.

22a. SIGNATURE: Paul Cohen M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): Paul Cohen

22d. ADDRESS: Church St. Snow Hill, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3-13-62

23c. NAME OF CEMETERY OR CREMATORY: Cool Spring Cem.

23d. LOCATION (City, town or county): Girdletree, (State) Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Samuel Lewis

ADDRESS: New Church, Va.

25a. REC'D BY REGISTRAR DATE: MAR 19 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kinna

TO PHYSICIAN OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
1SM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03976

CERTIFICATE OF DEATH

03972

1. PLACE OF DEATH
a. COUNTY: WORCESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
b. STATE: MARYLAND — b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
d. STREET ADDRESS: 107 WEST ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARGARET — Middle: ELIZABETH — Last: HENRY

4. DATE OF DEATH: Month: MAR. — Day: 3 — Year: 1962

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: JAN. 6, 1891

9. AGE (In years last birthday): 71 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (County & State, or foreign country): BALTIMORE MD

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: HENRY HOFF

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 213-22-7184

17. INFORMANT — Address: Mrs HAROLD DAVIS BERLIN

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocarditis
DUE TO (b): Chronic Myocarditis
DUE TO (c): Hypertension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-1, 1940 to 3-3, 1962 that (I) (we) last saw the deceased alive on 3-2-62 19, and that death occured 2 P.M, from the causes and on the date stated above.

22a. SIGNATURE: Clifford E. Schott M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): CLIFFORD E. SCHOTT M.D.

22d. ADDRESS: Berlin Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/5/62

23c. NAME OF CEMETERY OR CREMATORY: ST. PAULS CHURCHYARD

23d. LOCATION (City, town or county): BERLIN (State): MD

24. FUNERAL DIRECTOR'S SIGNATURE: Amon A. Burbage

ADDRESS: Berlin Md

25a. REC'D BY REGISTRAR DATE MAR 6 '62

25b. REGISTRAR'S SIGNATURE: Clarence E. Kime

IMPORTANT TO PHYSICIAN OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Item 18 Film 310 4-3-62 275

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03977

CERTIFICATE OF DEATH

03973

1. **PLACE OF DEATH**
a. COUNTY: WORCESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WORCESTER.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X BERLIN
d. STREET ADDRESS: 1 R. F. D.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First CLARA — Middle E. — Last JONES
4. **DATE OF DEATH**: Month MAR — Day 8 — Year 1962
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MAR. 20, 1893
9. AGE (In years last birthday): 68 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (County & State, or foreign country): SALISBURY MD
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: LEE RUARK
14. MOTHER'S MAIDEN NAME: JANIE LOWE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): NO
16. SOCIAL SECURITY NO.: NO
17. INFORMANT: Address: MRS. DONALD CROPPER, BERLIN MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pyelonephritis
DUE TO (b): Nephrosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 2 months
446 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3-8-62 19.., to 3-8-62, 19.., that (I) (~~We~~) last saw the deceased alive on 3-8-62 and that death occured 6:00 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Clifford E. Schott M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): CLIFFORD E. SCHOTT — 22d. ADDRESS: BERLIN, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 23b. DATE THEREOF: 3/12/62 — 23c. NAME OF CEMETERY OR CREMATORY: MT. ZION — 23d. LOCATION (City, town or county) (State): POWELLVILLE (RFD) MD.

24 FUNERAL DIRECTOR'S SIGNATURE: Anne A. Burbage — ADDRESS: Berlin Md — 25a. REC'D BY REGISTRAR DATE: MAR 14 '62 — 25b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO PHYSICIAN OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03978 — Reg. Dist. No. 03974

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fenwick Md
c. LENGTH OF STAY IN 1b: 10 Minutes
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Fenwick Md

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Delaware b. COUNTY: Sussex ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL Dagsboro 46x-3
d. STREET ADDRESS: Route 1
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: William Middle: Robbins Last: McCabe
4. DATE OF DEATH: Month: MAR Day: 24 Year: 1962
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8/1/93
9. AGE (In years last birthday): 68 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CARPENTER
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Near Selbyville, Del
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William R McCabe
14. MOTHER'S MAIDEN NAME: Mary Goddard
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 222-01-6491
17. INFORMANT: Address: Raymond E. Timmons Dagsboro, Del

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion, acute — INTERVAL BETWEEN ONSET AND DEATH: INSTANT
DUE TO (b): Arterio-sclerotic CVD with Severe Hypertension — 5 Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Francis J. Townsend Jr. M.D.
EXAMINER'S NAME (Type): Francis J. Townsend, Jr.
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Mar 24 62
Ocean City, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/27/62
22c. NAME OF CEMETERY OR CREMATORY: Dagsboro Cem.
22d. LOCATION (City, town, or county) (State): Dagsboro, Del.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Tilson & Gray Millsboro, Del.
24a. REC'D BY REGISTRAR DATE: MAR 29 '62
24b. REGISTRAR'S SIGNATURE: Arthur L. Evans

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

FOR STATE HEALTH DEPT.

M

X

I

0

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03979 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 03975

1. PLACE OF DEATH
a. COUNTY: Worcester
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Pocomoke City
c. LENGTH OF STAY IN 1b: 12 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): R.F.D. 2

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Pocomoke City
d. STREET ADDRESS: R.F.D. 2
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First HILLARY Middle HERMAN Last PUSEY

4. DATE OF DEATH: Month March Day 4 Year 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: June 21, 1880

9. AGE (In years last birthday): 81 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11 BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: A. D. Pusey

14. MOTHER'S MAIDEN NAME: Florence Pope

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No --

16. SOCIAL SECURITY NO.: 217-36-0139

17. INFORMANT: Mrs Sarah E. Pusey, Address R.F.D. 2, Pocomoke City, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: 0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) CORONARY ARTERY DISEASE — YEARS

DUE TO (c) GENERALIZED ATHEROSCLEROSIS

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: J. Ruth. La Mar M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

DATE SIGNED: 3-5-62

EXAMINER'S NAME (Type): Robert C/ La Mar, M.D. Address (Street, city, town, or county): 104 Bay St Snow Hill, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-6-62

22c. NAME OF CEMETERY OR CREMATORY: Salem Methodist

22d. LOCATION (City, town, or country) (State): Pocomoke City, Maryland

23. FUNERAL DIRECTOR: Henry A. Watson ADDRESS: Pocomoke City, Md.

24a REC'D BY REGISTRAR DATE: MAR 8 '62

24b. REGISTRAR'S SIGNATURE: Clifton L. Kruss

DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any d... necessary, ... e execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 ... should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may ... obtained for your files. 2 **FUNERAL DIREC...** Page 3 shou... used ... a burial-transit permit. File pages 1 and 2 wit... the State Board of Health, on its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02980 — 03976

(M) (I)

1. PLACE OF DEATH
a. COUNTY: Worcester
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
c. LENGTH OF STAY IN Md: 73 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, If institution, residence before admission)
a. STATE: Md
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
d. STREET ADDRESS
a. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Louis — Middle: W. — Last: Robins

4. DATE OF DEATH: Month: March — Day: 20 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 23–1888

9. AGE (In years last birthday) 73-4-27 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor

10b. KIND OF BUSINESS OR INDUSTRY: Church

11. BIRTHPLACE (County & State or foreign country): Snow Hill Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James T. Robins

14. MOTHER'S MAIDEN NAME: Betsy Duffy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown): Unk — (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: Unknown?

17. INFORMANT: Virgie E. Robins — Address: Snow Hill Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ACUTE PULMONARY EDEMA — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs
DUE TO (b): MYOCARDIAL INSUFFICIENCY — 1 YR
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from NOV 15, 1961, to MAR 20, 1962, that (I) (we) last saw the deceased alive on MAR 20 1962, and that death occured at 1 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Robt. C. LaMar — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 3/22/62

22c. PHYSICIAN'S NAME (Type): ROBERT C. LAMAR — 22d. ADDRESS: 164 BAY ST SNOW HILL, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial March 23/62 — 23b. DATE THEREOF — 23c. NAME OF CEMETERY OR CREMATORY: Mt Zion Baptist Cemetery — 23d. LOCATION (City, town or county): Snow Hill — (State): Md

24. FUNERAL DIRECTOR'S SIGNATURE: Alley E. Timmis — ADDRESS: Snow Hill, Md

25a. REC'D BY REGISTRAR DATE: MAR 23 '62 — 25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO PHYSICIAN OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03981 **CERTIFICATE OF DEATH** 03977

1

1. PLACE OF DEATH
a. COUNTY: WORCESTER
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
d. STREET ADDRESS: 1 WEST ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ROSA Middle: BELLE Last: STEPHENSON

4. DATE OF DEATH: Month: MAR Day: 18 Year: 1962

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JUNE 4, 1894

9. AGE (In years last birthday): 67 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (County & State, or foreign country): WILLARDS MD

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: FRANK WEBB

14. MOTHER'S MAIDEN NAME: BELLE CAREY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

16. (If yes, give year or dates of service): NO

16. SOCIAL SECURITY NO:

17. INFORMANT: MR. PAUL STEPHENSON Address: BERLIN MD

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Carcinoma of uterus with metastases — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Rheumatoid Arthritis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/13 1960 to 3/14 1962, that (I) ~~(we)~~ last saw the deceased alive on 3-14 1962, and that death occured at 1:43 AM, from the causes and on the date stated above.

22a. SIGNATURE: Ivory U. Sully, Jr. M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3/19/62

22c. PHYSICIAN'S NAME (Type): Ivory U. Sully, Jr. MD

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 3/20/62

23c. NAME OF CEMETERY OR CREMATORY: NEW HOPE

23d. LOCATION (City, town or county) (State): WILLARDS MD.

24 FUNERAL DIRECTOR'S SIGNATURE: Emma A. Burbage

ADDRESS: Berlin MD

25a. REC'D BY REGISTRAR DATE: MAR 22 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03982

CERTIFICATE OF DEATH

03978

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Stockton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Stockton
d. STREET ADDRESS: P.O. Box 125
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Nora — Middle: — Last: Townsend

4. DATE OF DEATH: Month: Mar. — Day: 13, — Year: 1962

5. SEX: F.

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 26, 1882

9. AGE (In years last birthday): 79 yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lewis Rowley

14. MOTHER'S MAIDEN NAME: Cora ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Elaine Hudson — Address: Girdletree, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: ? 1 hour
DUE TO (b): Arteriosclerotic Heart Disease — Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ... Feb ... 19 62, to ... March 19 62 that (I) (we) last saw the deceased alive on ... March 10 19 62, and that death occured at 10.14 M, from the causes and on the date stated above.

22a. SIGNATURE: David Rafat M.D.

22b. DATE SIGNED

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): DAVID RAFAT MD

22d. ADDRESS: Snow Hill Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3-18-62

23c. NAME OF CEMETERY OR CREMATORY: Home Beneficial Cem.

23d. LOCATION (City, town or county): Stockton, (State): Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Edgar Wharton

ADDRESS: New Church, Va.

25a. REC'D BY REGISTRAR DATE: MAR 21 '62

25b. REGISTRAR'S SIGNATURE: [illegible] S. Kraus

PHYSICIAN OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7 61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

03983

CERTIFICATE OF DEATH

03979

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City
c. LENGTH OF STAY IN 1b: 2 Hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 302 Market Street

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City
d. STREET ADDRESS: 212 Walnut Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle H. — Last TRADER

4. DATE OF DEATH: Month March — Day 10, — Year 1962

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 11, 1901
9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Telegraph Operator
10b. KIND OF BUSINESS OR INDUSTRY: Telegraph
11. BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Bowen Trader
14 MOTHER'S MAIDEN NAME: Cornelia Alice Tawes

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown, If yes, give war or dates of service): Yes — WW 2
16. SOCIAL SECURITY NO.: 577-09-4676
17 INFORMANT: Mrs Kathryn McMaster Trader, Address Pocomoke City, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a): Coronary Thrombosis, acute — INTERVAL BETWEEN ONSET AND DEATH: seconds

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

DUE TO (b): Coronary Atherosclerosis, chronic with 3 prior occlusions — years

DUE TO (c): Hypertensive C-V disease, mod. severe — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Generalized Atherosclerosis, chronic, severe

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from _____ 19___, to ___ , 19 , that (I) (we) last saw the deceased alive on Mar. 10, 19 62, and that death occurred at 9:45 A.M. P.M. the causes and an the date stated above

22a SIGNATURE: N. C. Sartorius, Jr. M.D
ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED
22c PHYSICIAN'S NAME (Type): N.E.Sartorius, Jr., M.D.
22d. ADDRESS: 114 Market St., Pocomoke City, Maryland

23a BURIAL, CREMATION REMOVAL (Specify): Burial
23b DATE THEREOF: 3-13-62
23c NAME OF CEMETERY OR CREMATORY: Bethany Methodist
23d LOCATION (City, town, or county) (State): Pocomoke City, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Henry T. Watson
ADDRESS: Pocomoke City, Md.
25a. REC'D BY REGISTRAR DATE: MAR 1 4 '62
25b. REGISTRAR'S SIGNATURE: T. L. Hum

TO ATTENDING PHYSICIAN: The law requires that the death certificate be ex... within 24 h... death. ... remained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete... filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. ... 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after d... ath.

VR A15 (4) 1SM 9/59

Item 21 - Film 309 3-27

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03984

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03980

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours. Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. **PLACE OF DEATH** a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): R I Ocean City
c. LENGTH OF STAY IN 1b: 15 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Beach Hwy at 71 St.

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission) a. STATE: Md — b. COUNTY: WOR
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): R I Ocean Coty, Md.
d. STREET ADDRESS: 191 St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First JAMES — Middle WALTER — Last WILLSON, JR.
4. **DATE OF DEATH**: Month MAR — Day 7 — Year 1962

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb 23 1908
9. AGE (In years last birthday): 54 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BUS DRIVER
10b. KIND OF BUSINESS OR INDUSTRY: TRAILWAYS
11. BIRTHPLACE (State or foreign country): Durlack, Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JAMES WALTER WILLSON
14. MOTHER'S MAIDEN NAME: EFFIE M. LEWIS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
16. SOCIAL SECURITY NO.:
17. INFORMANT: MRS Mattie G. Willson, WIFE, RI Ocean City Md

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): PENDING Autopsy Report. — INTERVAL BETWEEN ONSET AND DEATH:
420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Thrombosis of Coronary Artery — Unknown
DUE TO (c): Arteriosclerotic Heart Disease — Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Over exertion due to the big storm of March 7, 62.
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☒

ACTUAL SIGNATURE: J Townsend Jr M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): FRANCIS J TOWNSEND JR
Address (Street, city, town, or county):
DATE SIGNED: MAR, 9, 1962

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 3/10/62
22c. NAME OF CEMETERY OR CREMATORY: Fullerton Cem
22d. LOCATION (City, town, or country): FREDERICKSBURG (State): PA

23. FUNERAL DIRECTOR: Anna A. Burbage — ADDRESS: Berlin Md
24a. REC'D BY REGISTRAR DATE: MAR 13 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. Krome

Items 16&21 Film 511

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03985

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03981

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL 1 BERLIN
c. LENGTH OF STAY IN 1b: 18 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Residence

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Md — b. COUNTY: Wor
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural R1 x Berlin
d. STREET ADDRESS: RFD 1 Berlin
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: John — Middle: Scott — Last: Worth

4. DATE OF DEATH: Month: MAR — Day: 22 — Year: 62

5. SEX: M — 6. COLOR OR RACE: W — 7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] — 8. DATE OF BIRTH: (April 1, 1915) — 9. AGE (In years last birthday): 46 Yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): POULTRYMAN — 10b. KIND OF BUSINESS OR INDUSTRY: Poultry — 11. BIRTHPLACE (State or foreign country): Rehobeth, Md — 12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Hubert Worth — 14. MOTHER'S MAIDEN NAME: Effie Scott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No — 16. SOCIAL SECURITY NO.: 214-36-5258 — 17. INFORMANT (Address): Mrs Evaline H Worth (wife) R 1 Berlin, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PENDING // Autopsy // Report — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Carbrital Poisoning — Unknown
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
971.2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Mental depression, acute — 19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH. — 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED While at work [ ] Not While at work [ ] — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [ ], Suicide [X], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: F Townsend Jr M.D.
EXAMINER'S NAME (Type): Francis J. Townsend, JR
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city, town, or county): Ocean City, Md. (State)
DATE SIGNED: MAR 22, 62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Mar. 25, 1962 — 22c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park — 22d. LOCATION (City, town, or country) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR: HOLLOWAY & COMPANY — ADDRESS: SALISBURY, MARYLAND — 24a. REC'D BY REGISTRAR DATE: MAR 27 '62 — 24b. REGISTRAR'S SIGNATURE: Evelyn L. Krauss

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Where any delay is necessary, execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be obtained for your files.

VS. A15ME
5M 7/59